

NC DHB Pharmacy Request for
Prior Approval Nucala



Beneficiary Information

DMA-3609

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Prescriber DEA #: _____
Requester Contact Information
Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other: _____

Clinical Information

For initial therapy:

Asthma (answer questions 1-10)

1. Is the beneficiary age 12 or greater? Yes _____ No _____
2. Does the beneficiary have a diagnosis of severe asthma with an eosinophilic phenotype? Yes _____ No _____
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? Yes _____ No _____ Please list eosinophil count _____
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? Yes _____ No _____
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? Yes _____ No _____ Please List: _____
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes _____ No _____ Please List FEV1 value: _____
7. Is Nucala being used as add on maintenance treatment? Yes _____ No _____
8. Is Nucala being used for the treatment of other eosinophilic conditions? Yes _____ No _____
9. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus? Yes _____ No _____
10. Is Nucala being used as dual therapy with other monoclonal antibody treatments? Yes _____ No _____

For continuation of therapy:

Asthma (answer question 11)

11. Has the beneficiary experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Nucala treatment?
Yes _____ No _____ ****Please attach medical records to this request.**

For initial therapy:

Eosinophilic Granulomatosis with Polyangiitis (answer questions 12-13)

12. Is the beneficiary 18 years old or older? Yes _____ No _____
13. Does the beneficiary have a diagnosis of Eosinophilic Granulomatosis with Polyangiitis? Yes _____ No _____

For continuation of therapy:

Eosinophilic Granulomatosis with Polyangiitis (answer question 14)

14. Has the beneficiary shown clinical benefit from baseline supported by medical records since beginning Nucala? Yes _____ No _____
****Please attach medical records to this request.**

Signature of Prescriber: _____

** Prescriber Signature mandatory*

Date _____

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.